Complete Summary

GUIDELINE TITLE

Medication-assisted treatment for opioid addiction in opioid treatment programs: Approaches to providing comprehensive care and maximizing patient retention.

BIBLIOGRAPHIC SOURCE(S)

Approaches to providing comprehensive care and maximizing patient retention. In: Batki SL, Kauffman JF, Marion I, Parrino MW, Woody GE, Center for Substance Abuse Treatment (CSAT). Medication-assisted treatment for opioid addiction in opioid treatment programs. Rockville (MD): Substance Abuse and Mental Health Services Administration (SAMHSA); 2005. p. 121-42. (Treatment improvement protocol (TIP); no. 43).

GUIDELINE STATUS

This is the current release of the guideline.

COMPLETE SUMMARY CONTENT

SCOPE

DISEASE/CONDITION(S)

Opioid addiction

GUIDELINE CATEGORY

Evaluation
Management
Treatment

CLINICAL SPECIALTY

Family Practice
Internal Medicine
Psychiatry
Psychology

INTENDED USERS

Nurses
Physicians
Psychologists/Non-physician Behavioral Health Clinicians
Social Workers
Substance Use Disorders Treatment Providers

GUIDELINE OBJECTIVE(S)

To increase patient retention in medication-assisted treatment for opioid addiction (MAT) and the likelihood of positive treatment outcomes

TARGET POPULATION

Patients with an addiction to opioids who are eligible for medication assisted treatment programs

INTERVENTIONS AND PRACTICES CONSIDERED

Management

1. Core Services
    - Basic-Care Services
    - Extended-Care Services
    - Meeting service needs (substances of abuse, medical needs staffing needs, offsite treatment options)
2. Retaining patients in medication-assisted treatment for opioid addiction (MAT)
3. Counseling and case management
    - Individual counseling
    - Group counseling
    - Social services case management
4. Cognitive and behavioral therapies
5. Psychotherapy
6. Counseling for effects of sexual abuse
7. Counseling for HIV/AIDS and hepatitis C
8. Coping with patients who resist counseling and psychotherapy
9. Patient education and psychoeducation
10. Family interventions
11. Integrative approaches
    - Peer support or mutual-help programs
    - Other support groups
12. Relapse prevention
    - Multiple substance use
    - Relapse warning signs
    - Patient follow-up strategies

13. Referral to social services
14. Involuntary discharge from MAT
    - Reasons for administrative discharge
    - Preventing and finding alternatives to administrative discharge
    - Procedures for administrative discharge
15. Patient advocacy

MAJOR OUTCOMES CONSIDERED

- Positive treatment outcome
- Retention in treatment
- Relapse rate
- Patient satisfaction

METHODOLOGY

METHODS USED TO COLLECT/SELECT EVIDENCE

Hand-searches of Published Literature (Primary Sources)
Hand-searches of Published Literature (Secondary Sources)
Searches of Electronic Databases

DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE

The literature search involved careful consideration of all relevant clinical and health services research findings, practice experience, and implementation requirements.

NUMBER OF SOURCE DOCUMENTS

Not stated

METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE

Expert Consensus

RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE

Not applicable

METHODS USED TO ANALYZE THE EVIDENCE

Systematic Review

DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE

Not stated

METHODS USED TO FORMULATE THE RECOMMENDATIONS

Expert Consensus

DESCRIPTION OF METHODS USED TO FORMULATE THE RECOMMENDATIONS

After selecting a topic, Center for Substance Abuse Treatment (CSAT) invites staff from pertinent Federal agencies and national organizations to be members of a resource panel that recommends specific areas of focus as well as resources that should be considered in developing the content for the Treatment Improvement Protocols (TIP). These recommendations are communicated to a consensus panel composed of experts on the topic who have been nominated by their peers. This consensus panel participates in a series of discussions. The information and recommendations on which they reach consensus form the foundation of the TIP. The members of each consensus panel represent substance abuse treatment programs, hospitals, community health centers, counseling programs, criminal justice and child welfare agencies, and private practitioners. A panel chair (or co-chairs) ensures that the contents of the TIP mirror the results of the group's collaboration.

RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS

Not applicable

COST ANALYSIS

A formal cost analysis was not performed and published cost analyses were not reviewed.

METHOD OF GUIDELINE VALIDATION

External Peer Review

DESCRIPTION OF METHOD OF GUIDELINE VALIDATION

A large and diverse group of experts closely reviews the draft document. Once the changes recommended by these field reviewers have been incorporated, the Treatment Improvement Protocol (TIP) is prepared for publication, in print and on line.

RECOMMENDATIONS

MAJOR RECOMMENDATIONS

The consensus panel agrees that a well-planned and well-supported comprehensive treatment program increases patient retention in MAT and the likelihood of positive treatment outcomes.

Core Services

Basic-Care Services

The minimum required services for medication-assisted treatment for opioid addiction (MAT) are outlined in Federal regulations but individual program requirements vary according to State standards, accreditation requirements, and local factors. The consensus panel recommends that opioid treatment programs (OTPs) offer at least the following services:

- Comprehensive psychosocial assessment
- Initial and yearly medical assessment (physical examination and laboratory testing)
- Medication dispensing
- Drug tests
- Identification of co-occurring disorders and neuropsychological problems
- Counseling to stop substance abuse and manage drug craving and urges
- Evaluation of and interventions to address family problems
- Human immunodeficiency virus (HIV) and hepatitis C virus (HCV) testing, education, counseling, and referral for care
- Referral for additional services as needed

Extended-Care Services

Many patients in MAT have other problems affecting their recovery, including medical, social, family, vocational, and legal problems and co-occurring disorders. Assessing and addressing these problems are important to facilitate recovery from addiction. Various strategies have been developed, including psychosocial and biomedical interventions and peer-support approaches.

Managing an OTP To Meet Service Needs

Substances of Abuse

Increasingly since the 1980s, patients have entered OTPs with other addictions, particularly to alcohol, cocaine, marijuana, nicotine, or other sedatives and stimulants. In addition, adolescent and young adult patients often smoke or snort rather than inject heroin, and more patients are addicted to opioid analgesics, such as oxycodone, taken orally. To manage these developments, OTPs should evaluate and modify their core substance abuse treatment services continuously, based on the changing needs of their patient populations.

Medical Needs

People addicted to opioids are at greater risk for sexually transmitted diseases (STDs), pneumonia, and other debilitating conditions that require intensive medical services. Infected injection sites, cellulitis, and abscesses are increasingly common. Bacterial endocarditis remains a concern. Long-term tobacco use contributes to other diseases.

Staffing Needs

Program administrators need to develop comprehensive patient population profiles for planning, staffing, and resource allocation. Managers should provide an appropriate mix of staff for specific patient characteristics and needs and should

determine the range of services that can be provided with available funds. Unfunded services should be covered by referral to affiliated agencies. Positive, sustained outcomes are more attainable in a therapeutic environment with readily available, supportive, qualified caregivers. It is difficult to provide high-quality care and facilitate favorable treatment outcomes in a chaotic OTP environment with unqualified or overburdened staff and managers and unreasonable caseloads.

Offsite Treatment Options

The consensus panel urges OTPs to provide as many basic- and extended-care services as possible on site. OTPs that lack the resources to provide or sponsor the comprehensive list of services recommended in this Treatment Improvement Protocol (TIP) should engage in active case management while working with other agencies and specialized service providers and educating these collaborators about MAT. Accreditation requirements increasingly are motivating OTPs to pursue these collaborations.

Retaining Patients in MAT

Importance of Retention

Studies of patients who left MAT prematurely have determined that length of retention was the most important indicator of treatment outcomes.

Improving Patient Retention

Factors Affecting Patient Retention

Patient characteristics, behavior, and other factors unrelated to treatment have been found to contribute relatively little to retention in MAT. One comprehensive study found that retention was determined almost entirely by what happened during treatment, not before, although two factors, older age and less involvement with the criminal justice system, predicted longer retention. Another factor found to affect retention was motivation or readiness for treatment.

OTPs should not consider patients' prior failures indicative of future compliance or retention or use these failures as reasons to reject those seeking readmission.

Recommended Steps to Improve Patient Retention

Individualize Medication Dosages

Adequate, individualized medication dosages are probably the most important factor in patient retention because they contribute to patient comfort and satisfaction by reducing withdrawal symptoms and craving and enabling more attention to other concerns.

Clarify Program Goals and Treatment Plans

Treatment providers should explain program goals and treatment plans to every patient. Inconsistent messages adversely affect patient retention, particularly

when these messages are about the advisability of remaining in MAT versus tapering from medication. Goals related to medication should be individualized and respectful of patient's wishes and goals, but they should incorporate knowledge and research about retention in MAT. Treatment planners should realize that, regardless of OTP recommendations, some patients want to taper from maintenance medication more quickly than seems advisable. Staff should work with these patients to achieve their goals in a reasonable timeframe.

OTP practices and communication with patients should conform to best treatment practices. Setting maximum lengths of stay for all patients or emphasizing low-dose medication goals can discourage retention and produce poor outcomes. Rigid operating practices (e.g., requiring extensive travel, inconvenient hours, long waits, frequent pickups) may lower retention and disrupt treatment. Patients have cited other factors that discourage retention, such as staff insensitivity, lack of treatment skills and knowledge, and limited contact.

Simplify the Entry Process

Shortening intake results in better program retention.

Attend to Patients' Financial Needs

Patients' inability to pay may limit both treatment entry and retention, especially in States where MAT is not covered by Medicaid, State funds, or private insurance. OTP staff members should work proactively with patients to apply for benefits covering treatment costs, investigate health insurance and work with existing insurers, and develop hardship payment plans.

Reduce the Attendance Burden

Attendance requirements can exert powerful effects on retention. One study found that patients who were required to visit an OTP less frequently were less likely to drop out of treatment and no more likely to use other drugs than patients on a daily attendance schedule.

Provide Useful Treatment Services as Early as Possible

Patients were more likely to stay in treatment when they were motivated strongly and engaged earlier in useful activities. In the critical first 90 days of treatment, higher service intensities, especially for practical services that helped patients achieve basic goals, have been associated with higher retention. Examples include attentive case management, psychiatric services, introduction to peer groups, and assistance with insurance, transportation, and housing.

Enhance Staff-Patient Interactions

Good staff attitudes and interactions with patients have been associated with higher retention. Some treatment providers have found that patients are more likely to remain in treatment when they are involved in its planning and management. Increased interaction with staff increases communication and information flow, limits problems, and contributes to patients' sense of well-being.

Unfortunately, funding constraints often reduce communication training for staff and opportunities to improve patient-to-staff ratios.

Improve Staff Knowledge and Attitudes About MAT

OTP staff members should understand MAT and appreciate the wealth of science supporting it, and they should be aware of recommended treatment practices so that they can interact effectively and constructively with patients. Staff members should express confidence in MAT when communicating with patients. Attitudes critical of extended pharmacotherapy have been found to be common (even dominant) among many counselors and evoke frequent patient complaints.

Counseling and Case Management, Behavioral Treatments, and Psychotherapy

Counseling and Case Management

The consensus panel recommends that counseling in MAT focus on

- Providing support and guidance, especially to eliminate substance use
- Monitoring other problematic behaviors
- Helping patients comply with OTP rules
- Identifying problems that need extended services and referring patients for these services
- Identifying and removing barriers to full treatment participation and retention
- Providing motivational enhancement for positive changes in lifestyle

The standard components of substance abuse counseling should include

- Assistance in locating and joining mutual-help groups or peer support groups such as Narcotics Anonymous (NA) or Methadone Anonymous (MA)
- Education about addiction and the effects of substances of abuse
- Education about relapse prevention strategies
- Identification of unexpected problems needing attention, such as sudden homelessness
- Assistance in complying with program rules and regulations
- Information about stress- and time-management techniques
- Assistance in developing a healthy lifestyle involving exercise, good nutrition, smoking cessation, and avoidance of risky sexual practices
- Assistance in joining socially constructive groups such as community organizations and faith-based groups
- Continuing education on health issues (particularly HIV/AIDS and hepatitis)

Counseling sessions to relieve patients' anxiety about MAT and reassure them about its efficacy are of paramount importance during the first weeks of treatment. Usually, individual sessions during the acute phase are more intensive than those that follow, although individual needs should dictate the frequency and duration of counseling.

Individual Counseling

As MAT progresses, patients should continue meeting with counselors in individual sessions, once per month to several times per week depending on need, the phase of treatment, and State regulations. In some States, Medicaid regulations and contracts require or limit counseling frequency. MAT counselors should continue to identify patients' needs and refer them to or arrange for other services (e.g., housing, medical and psychiatric care, legal services).

A typical individual counseling session, as envisioned by the consensus panel, might include any of the following activities:

- Reviewing how a patient feels, is coping with cravings, or is changing his or her lifestyle
- Reviewing drug test results and what they mean
- Identifying emergencies and deciding how to address them
- Reviewing the treatment plan
- Identifying measurable goals and reasonable timeframes
- Reviewing progress in achieving goals, including abstinence and related behaviors
- Discussing dosage and take-home medications
- Discussing legal concerns, such as reporting to probation officers and complying with the terms of probation or parole
- Discussing family concerns
- Providing liaison services (e.g., with physicians, courts, social service agencies)
- Addressing routine issues (e.g., transportation, childcare)

Medical staff should educate counselors about patients' medical problems so that counselors can help patients understand the importance of keeping appointments for and complying with medical treatment. Counselors should convey observations to medical staff about patients' conditions and information about other aspects of patients' lives that might clarify health problems. Although counselors are not expected to understand medical treatments, pathophysiology, or pharmacotherapy in the same way as medical professionals do, they should have general knowledge of common medical conditions affecting patients in MAT and their treatments--especially how treatments for these conditions can interact with addiction treatment medications. Counselors can help patients cope with hepatitis C and adhere to its treatment regimens. Many patients have been exposed to HCV infection, and effective treatment requires motivation and support from the entire treatment team.

Group Counseling

Group counseling has some advantages over individual counseling and therapy. It can reduce patients' sense of isolation and help them cope with addiction and other life problems by providing feedback from peers, social skill training and practice, structure, discipline, and encouragement. Through peer interaction, patients contribute to one another's recovery. Trained individuals should lead these groups. Some State agencies offer courses in group process and dynamics.

The following types of groups are used commonly in MAT:

- Psychoeducational groups

- Skill development groups, such as relapse prevention, stress management, and substance use cessation groups, which help patients learn skills to attain and maintain abstinence
- Cognitive behavioral groups, in which patients learn to alter pervasive thoughts and actions
- Interpersonal-process groups, which delve into developmental issues contributing to addiction or interfering with recovery
- Support groups, which buoy members and provide a forum to share pragmatic information about maintaining abstinence and managing a day-to-day substance-free lifestyle

In some OTPs, group membership is linked to the phase of a patient's treatment. Some groups keep the same membership but stay together for a short time; others are longer term and have a rolling membership—that is, frequent membership changes, with new members entering when they are ready. Neither type of group needs a predetermined end point or set timeframe. Using a manual with a structured curriculum enables counselors and other staff members to lead some groups. Manuals increase flexibility in resource-limited OTPs and the likelihood that groups cover standard information. Manuals for group counseling in MAT are less common than for general substance abuse counseling. However, the consensus panel believes that the principles used for non-MAT groups can be adapted easily to groups in MAT.

Some patients resist group counseling and avoid sessions. Offering smaller groups might ease their concerns while therapists explore the reasons for their resistance (e.g., fear of talking in groups or confidentiality concerns). In general, an OTP should consider a group's patient mix. Some patients with co-occurring disorders do better in groups with members who have similar conditions. However, some patients with severe co-occurring disorders cannot participate in groups, and some have problems that require individual counseling.

A patient's gender or sexual orientation can be important in choosing individual or group counseling. Some women are uncomfortable in male-dominated groups and do better in women-only groups. Others feel embarrassed about personal subjects related to their addiction. Gay men, lesbians, and bisexuals might feel isolated in predominantly heterosexual groups. In such cases, the consensus panel recommends individual, women-only, or sexual-orientation-specific groups.

Social Services Case Management

Some researchers have investigated the usefulness of social service-focused case management in addiction treatment settings such as OTPs. The authors of one study concluded that social service-focused case management was an important and effective adjunct to addiction treatment.

Cognitive and Behavioral Therapies

Other interventions, both in use and under study, include cognitive-enhanced techniques to increase treatment participation, modify behavior, and address patients' social, emotional, and behavioral problems, as well as any co-occurring disorders.

Behavioral treatments in MAT are derived from principles of cognitive learning and behavioral change developed by psychologists and behavior scientists. The consensus panel believes that substance abuse and addiction involve major learning elements and are influenced by patients' environments and circumstances. Many elements of cognitive behavioral therapy (CBT)--for example, emphases on identifying high-risk circumstances that may trigger an event and developing coping responses--are accepted and incorporated widely into substance abuse education and counseling. CBT is associated with increased treatment compliance and improved treatment outcomes.

Node Link Mapping

Node-link mapping is a cognitive-enhanced technique that uses flowcharts and other visual aids to diagram relationships between patients' thoughts, actions, and feelings and their substance use and to increase patient participation in counseling. Studies have found that node-link mapping encouraged communication about topics such as family, job, and substance use and improved participants' motivation, self-esteem, and rapport with counselors.

Community Reinforcement Approach

The community reinforcement approach (CRA), originally developed to treat alcoholism, is another effective model for MAT. This multicomponent treatment facilitates change in a patient's daily environment. CRA counselors work with patients to identify aspects of their lives that reinforce abstinence and to understand how these reinforcers can serve as alternatives to substance use. CRA has been found to reduce opioid use and produce other positive outcomes either with or without voucher-based incentives.

Contingency Management

Contingency management reinforces desired behavior with immediate incentives. Its efficacy has been demonstrated in several well-designed studies. Incentives were found to increase such desirable outcomes in MAT as negative drug tests, attendance at counseling and medical appointments, working, and volunteering. This approach is useful for treatment planning because it sets concrete goals and emphasizes positive behavioral changes. The table below titled "Strategy for Contingency Management in MAT" summarizes this strategy in MAT.

Strategy for Contingency Management in MAT
• Pick a target behavior that can be measured easily (e.g., stopping opioid abuse). • Select a reward that can be given as soon as the desired behavior (e.g., three consecutive negative drug test results) is documented. The reward should be nonmonetary (e.g., nonrefundable movie passes, take-home medication privileges). • Specify the link between targeted behavior and the reward. For example, a negative drug test result might earn one take-home medication dose (other treatment and program variables must be taken into account, including Federal and State regulations). • Put the contract in writing, specifying its duration and any changes over time

Strategy for Contingency Management in MAT
in contingencies (e.g., after 3 substance-free weeks, the patient can receive take-home privileges).

The consensus panel emphasizes that effective contingencies usually involve positive reinforcement. Positive contingencies or rewards are more effective than negative, punishing contingencies or threats. Negative consequences tend to drive patients from treatment. Tangible rewards, such as take-home medication privileges, should be paired with social reinforcements, such as praise from the counselor or other patients, to optimize their value.

A popular, effective reward in OTPs is the medication take-home privilege. Other incentives may include special scheduling for medication administration, meal vouchers, gift certificates, entertainment tickets, or toys for patients' children. Designing such programs requires significant effort, yet the rewards can add an important dimension to MAT.

To be most effective, behavior contingencies should be defined clearly and implemented consistently. Contingencies may be individualized based on each patient's targeted areas of behavioral change or implemented on a uniform, program-wide basis. Tailoring behavioral contingencies to patients' needs has been found to work better.

The consensus panel emphasizes that, when contingency management is used to control use of short-acting drugs, objective measures should provide the basis for withholding incentives. Testing frequency (both randomly and, when feasible, regularly at least once per week) must be adequate to detect short-acting drugs.

Motivational Enhancement

Motivational enhancement has emerged as a component of counseling in MAT, although the effectiveness of motivational interviewing in MAT needs more investigation.

Psychotherapy

Psychotherapy is a form of verbal-expressive therapy in which a trained therapist uses psychological principles to modify or remove problematic thoughts feelings, and behaviors. Whereas counseling focuses on the here-and-now, decision making, values, self-concept, strengths, and goal setting, psychotherapy focuses on changes in personality, and psychoanalytic psychotherapy attends to the subconscious.

Because many patients are unstable during the acute phase of MAT, providers usually delay psychotherapy until later in the acute phase or in the rehabilitative phase, but views differ on when psychotherapy is appropriate. The consensus panel believes that psychotherapy has an important role in MAT but that it usually should be deferred until patients are stabilized. The table below titled "Common Strategies for Psychotherapy in MAT" summarizes consensus panel recommendations for psychotherapy in MAT.

Common Strategies for Psychotherapy in MAT
• Devote part of each session to addressing patients' most recent successes and failures regarding their substance use. • Adopt a more active therapist role than typically required for co-occurring disorders. • Strengthen patients' resolve to stop substance use (help them visualize or recall life without drugs to replace memories of enjoyable drug use). • Teach patients to recognize warning signs of relapse and develop coping skills. • Support patients' rearranging priorities so that they are not preoccupied with substance use. This might involve their acquiring job skills, developing hobbies, or rebuilding relationships. • Assist patients in managing painful affects. (From a psychodynamic approach, this involves exploring the causes of such feelings.) • Help patients enhance interpersonal functioning and social supports so that the rewards of friendship and relationships replace those of substance use. • Use psychotherapy only after a strong therapeutic alliance has developed with the patient or other supportive structures are in place to guard against relapse.

Staff Qualifications

Staff members responsible for psychotherapy should have more specialized training than those responsible for drug-focused counseling. Psychotherapists should possess advanced degrees and undergo supervised training. If OTPs lack staff or resources for psychotherapy, patients should be referred elsewhere. OTPs should verify and document the degrees and licensure of those providing psychotherapeutic services.

Group Psychotherapy

Group psychotherapy and group counseling with an interpersonal, process, or psychodynamic focus can be effective interventions in MAT. These groups should be flexibly structured and focus on interpersonal-relationship building, self-insight, reflection, and discussion. Patients should be selected carefully for these groups and should be able to commit to the process. Group treatment can provide a sense that individuals are not alone in addressing problems, even serious ones. Such normalization is often a first step toward feeling less isolated and developing new coping strategies.

Other Topics

Effects of Sexual Abuse

The consensus panel recommends specialized training for counselors and therapists treating patients who have been sexually abused or referral of these patients to qualified mental health care providers.

Counseling for Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome (HIV/AIDS) and Hepatitis C

Counseling about the increased risks of HIV and hepatitis C virus (HCV) infection arising from drug injection and risky sexual behavior is essential for patients in MAT. Many States require that patients receive specialized HIV counseling before and after they receive HIV antibody tests and require that patients be encouraged to ask questions about HIV. Pretest HIV counseling should be factual and medically based. For patients who test negative for HIV, posttest counseling should address how they can reduce infection risk. Patients with positive HIV test results need referrals for medical care and counseling about what the tests mean, coping with problems and issues raised by the results, treatment options, participation in clinical trials if available, support groups, and behaviors to prevent infecting others or contracting another HIV strain. Rapid HIV tests have been approved by the Food and Drug Administration and are recommended by the U.S. Public Health Service for point-of-care diagnosis of HIV infection in settings such as OTPs. If an OTP cannot provide onsite testing and counseling, it should develop referral relationships for outside diagnosis and treatment. The consensus panel recommends onsite counseling whenever possible.

Coping with Patients Who Resist Counseling and Psychotherapy

Some patients resist counseling, psychotherapy, and other treatments out of fear and distrust. They may perceive that proposed treatments will not meet their needs, or they find staff insensitive or uneducated. Some patients may begin MAT to address other aspects of their lives rather than to stop substance use. Others have been pressured into MAT by the courts.

Patient Education and Psychoeducation

Patient education and psychoeducation are useful in comprehensive MAT and can be performed in group or individual sessions. Both types of education may involve presenting information about substance abuse and addiction to patients alone, in groups, or with their families. Psychoeducation addresses the full range of patient needs, including education, personal development, recreation, health, and vocational or relationship needs, while addressing patient attitudes and feelings to ensure that a message is understood and internalized. Psychoeducational models, when used with other treatment approaches, increase a patient's ability to function independently and meet his or her daily needs outside the OTP. See table below titled "Strategies for Psychoeducation in MAT".

Strategies for Psychoeducation in MAT
• Introduce psychoeducation at the beginning of treatment so that it serves as an orientation to both OTP operational and recovery processes. • Involve family members and selected friends, with a patient's informed consent. Provide guidance in how to support the patient's recovery efforts. • Adapt educational strategies and materials to the patient's culture and family. • Discuss methadone and other treatment medications, and dispel the myths related to their use (e.g., "methadone rots the bones," "it's impossible to get off methadone"). • Discuss the implications of continuing substance abuse. Question assumptions about alcohol and drug use, and clarify that such use undermines recovery. • Discuss sexual behaviors that may affect relapse, including exchanging sex for drugs, drug use to function sexually or enhance sex, sexual abstinence, and intimacy or sex while substance free.

Strategies for Psychoeducation in MAT
• Discuss the power of triggers with patients and families. For example, merely discussing heroin can be a trigger for resuming its use. • Incorporate special groups to discuss parenting, childcare, women's issues, and coping with HIV/AIDS and HCV infection. Use generic names for HIV/AIDS groups (e.g., "health care issues" group) to avoid stigma.

Common topics in patient educational sessions include

- Physical and psychological effects of opioid and other substance abuse
- Health education information, including medical problems related to addiction, smoking cessation, improving nutritional habits (including special needs of persons with HIV), and exercise, including aerobic and meditative exercises (e.g., yoga)
- Effects of drug use on family and other relations
- Introduction to mutual-help groups such as Methadone Anonymous
- Effects and side effects of addiction treatment medications and interactions with other drugs
- Symptoms of co-occurring disorders
- Compulsive behaviors besides substance abuse (e.g., gambling, sexual behaviors)
- Skills to attain and sustain abstinence, such as anger management and coping with cravings
- Developing non-drug-related leisure activities
- Stress management and relaxation
- Communication skills and assertiveness training
- Time management
- Parenting skills
- Avoidance of sexually transmitted diseases (STDs) and promotion of responsible sexual behavior
- Vocational planning and employment (sometimes linked with cognitive testing and conducted with vocational agencies)

Benefits of Family Involvement

The consensus panel believes that family involvement in treatment provides strong support for patient recovery and that family members also benefit. The concept of "family" should be expanded to include members of the patient's social network (as defined by the patient), including significant others, clergy, resource people from the community, and others.

Types of Family Interventions

Family involvement usually takes the form of family counseling or family education. Some OTPs hold short family education sessions about MAT, substance use disorders and their effects on the family, and family dynamics. Holding sessions for several families can be cost effective, supportive, and mutually beneficial. Family counseling usually consists of one or more discussion sessions that provide information and allow participants to express their feelings and concerns. Some OTPs have monthly family nights or informal gatherings for

ongoing communications between patient families and counselors. These continuing forums help secure family support for patient treatment and identify acute family problems needing focused therapy.

The consensus panel recommends that, because complex factors affect patients' families, family therapy should be provided only by trained staff and reserved for families with serious problems with behaviors or attitudes that contribute to patients' addictions, which, if unchecked, might affect recovery. Because many OTPs do not provide family therapy, referrals to community-based services often are needed, and the consensus panel urges that such connections be established. Family therapy may be more effective for some patients than individual counseling, group therapy, or family psychoeducation.

Children of Patients in MAT

Many children of patients in MAT have emotional and cognitive problems. They are more vulnerable to physical and sexual abuse and neglect and may exhibit more behavioral problems, substance use, criminal involvement, conduct problems, and other social and intellectual impairments than other children. Child assessment requires trained personnel and may be unrealistic for some OTPs. OTPs can make referrals to appropriate resources and are encouraged to provide parenting support groups, skill development groups, family therapy, or referral for child and family therapy.

Counselors should be aware of reporting requirements in their State, and patients should be advised that confidentiality protections do not apply if a patient must be reported to authorities for child abuse or neglect. A counselor who determines that a patient is neglecting or abusing young children is required to report the neglect or abuse. Licensed professional staff members (physicians, psychologists, nurses, social workers) are mandated to report child neglect and abuse. In some States, any person who observes this situation is required by law to report it to local authorities.

Few OTPs are equipped to address the needs of children whose family members abuse opioids. Treatment providers can ask about the mental health and adjustment of patients' children and consider routine psychiatric screening and early intervention and treatment for these children. Behavioral training may provide their parents with improved parenting techniques.

Parenting Groups

Many patients entering OTPs are in danger of losing custody of their children or already have lost custody. Some patients in MAT might have separate agreements with children's protective services (CPS) agencies about what they must do to keep or regain custody of their children. OTPs should treat these patients with respect and avoid displaying negative feelings about their involvement with CPS agencies. In cases in which child custody is at issue, the consensus panel recommends that, once these patients are stable, treatment focus on concerns about custody, children, and parenting. Parenting groups are one useful approach.

Some parenting groups are educational, addressing topics such as interacting with CPS agencies, resource availability, daycare services, and breast-feeding during

MAT. Skill-building groups for parents in MAT often address process issues, such as setting limits, appropriate and consistent discipline, divorce, visitation, noncustodial parenting, and tending to sick children.

Psychodynamic parenting groups take a more intensive approach, exploring topics such as ambivalence about losing child custody, fear of parenting, and coping with anger, shame, or guilt. OTPs should develop parenting groups based on the needs expressed by patients.

Domestic Violence

Men and women in MAT may be victims of domestic violence. It is estimated that at least three-quarters of women in MAT experienced partner violence. Counselors should incorporate appropriate assessment procedures, referrals, or treatment responses for violence. They might have to help patients remove themselves from dangerous situations. Counselors should have a broad view of domestic violence that includes female (to male) aggression, same-sex physical and emotional abuse, and issues related to elder abuse. Because many patients are in domestic violence situations, OTPs should provide general didactic groups or seminars and other resources addressing domestic violence. Treatment resources for victims should be integral parts of treatment strategies.

Integrative Approaches

Integrative approaches to MAT complement and enhance OTP efforts with resources from the community. Peer support, or mutual-help, programs are the most common such resources. OTPs offering comprehensive treatment should have the flexibility and resources to integrate available, beneficial services from the community.

Peer Support, or Mutual-Help, Programs

The most popular, widely used mutual-help models are 12-Step recovery programs, such as Alcoholics Anonymous (AA), Narcotics Anonymous (NA), Methadone Anonymous (MA), and Cocaine Anonymous (CA), which have been effective in helping people remain abstinent from substances and can be important augmentations to therapy. They are sources for social support, peer identification, relapse prevention, and treatment reinforcement, and they provide role models for successful recovery. Members of support groups gain strength and security from others who understand and share their concerns and who offer practical strategies for surviving "one day at a time."

Decreases in substance abuse among group participants have been associated with attending meetings frequently, obtaining a sponsor, "working" the 12 Steps, and leading meetings. However, 12-Step groups are not for everyone. Some groups do not support MAT, and many advocate an approach that may conflict with a patient's personal beliefs. Patients should not be pressured to attend support groups. Rather, an OTP staff member should explain that participation has helped many patients. Resistance to attendance should be discussed and respected. Every effort should be made to help a patient find an appropriate peer support program. Many creative strategies have evolved to promote mutual-help

programs, such as simulated meetings to introduce patients to the language, customs, and rules of groups.

Other Support Groups

Groups also exist for friends and relatives of persons in recovery (e.g., Nar-Anon) and of others who refuse treatment. The following groups offer support and teach participants to curb their destructive behaviors:

- Chemically Dependent Anonymous, www.cdaweb.org
- Cocaine Anonymous, www.ca.org
- Double Trouble in Recovery, www.doubletroubleinrecovery.org
- Dual Disorders Anonymous
- Dual Recovery Anonymous, www.draonline.org
- Families Anonymous, www.familiesanonymous.org
- Women for Sobriety, www.womenforsobriety.org
- Secular Organizations for Sobriety (SOS), www.cfiwest.org/sos
- SMART Recovery Self-Help Network (Self-Management and Recovery Training), www.smartrecovery.org

Other Approaches

In acupuncture, thin needles are inserted subcutaneously at points on the body for therapeutic purposes. Some believe that acupuncture can relieve pain, anxiety, and withdrawal symptoms related to substance abuse, although little empirical evidence exists. Some patients appear to benefit from acupuncture as an adjunct to MAT.

Other approaches to self-help and peer support that might be integrated with MAT include meditation classes; exercise programs; classes in diet, nutrition, and health; and trauma groups. More research is needed on the benefits of these activities and treatments in MAT.

Relapse Prevention

Because opioid addiction is a chronic relapsing disease, the consensus panel recommends that strategies specifically directed at relapse prevention be an important part of comprehensive MAT in any OTP. See the table below titled "Patient Goals in Building Relapse Prevention Skills" for consensus panel recommendations for assisting patients in building their relapse prevention skills.

Patient Goals in Building Relapse Prevention Skills
• Understand relapse as a process, not an event. • Develop new coping skills for high-risk situations. • Make lifestyle changes to decrease the need for drugs. • Increase participation in healthy activities. • Understand and address social pressures to use substances. • Develop a supportive relapse prevention network (e.g., with significant others). • Develop methods of coping with negative emotional states. • Learn methods of coping with cognitive distortions.

Patient Goals in Building Relapse Prevention Skills
• Develop a plan to interrupt a slip or relapse. • Recognize relapse warning signs, including internal and external triggers and warning signs. • Combat memories of drug abuse-associated euphoria. • Reinforce recollections of negative aspects of drug use. • Overcome the desire to attempt to regain control over use of illicit drugs or abuse of alcohol or prescription drugs. • Avoid people, places, and things that might trigger drug use. • Develop pleasurable and rewarding alternatives to drug use.

Education about relapse is a key part of treatment. Educational approaches should teach concrete strategies to avoid drug relapse and should address the goals listed in the table above. Additional topics may include cataloging and avoiding high-risk situations and coping with drug cravings and slips to prevent full-blown relapses. Relapse prevention strategies often distinguish between slips and relapses, with slips defined as milder episodes of use. Of course, no level of opioid use should be condoned, but when a relatively mild and isolated episode occurs, the consensus panel recommends that OTP staff members focus on implementing the best available prevention strategy to ensure that a severe relapse is avoided.

Relapse Prevention Strategies for Multiple Substance Use

Patients who abuse multiple substances may require modified relapse prevention strategies. Patients may use formerly coadministered substances separately, which can increase the chance of sequential lapses leading to full relapse. Separate interventions may be necessary for each substance because the associated risks of relapse are different for each. Perceptions of actual relapse risks for the same drug can differ among patients. For example, a patient may associate heroin use with socializing and cocaine use with alleviating depression.

Some researchers have noted that an abstinence violation effect may occur when a patient abstains from a substance but then relapses and possibly overuses it. The patient's reaction varies and often is contingent on how much he or she perceives relapse as a personal failure. When a slip or lapse occurs, the patient's self-esteem can be lowered, which he or she may attempt to repair by continuing or increasing substance use. Treatment providers should be alert to this phenomenon and educate patients about it.

Recognizing Relapse Warning Signs

Indications of a patient's mistaken beliefs or rationalization might precede relapse and provide intervention points for a therapist. It is critical that a counselor or therapist know these warning signs, including the following:

- The illusion of feeling cured after a few weeks or months of abstinence
- The belief that one can control his or her substance use and can use substances socially
- Idealized recollections of drug-induced euphoria; remembering the pleasurable effects but selectively forgetting adverse effects

- Overreactions to urges and cravings, leading to beliefs that treatment is ineffective or abstinence is unsustainable
- Denial of vulnerability to and refusal to accept the possibility of relapse, leading to overreaction when relapse occurs (causing patients to drop out of treatment)
- Entry into high-risk situations, denial of risks, and self-testing or self-sabotage.

Extinction Therapy

Behavior therapy using cue exposure treatment (extinction) was designed to reduce drug craving by repeated exposures to an experience that previously triggered drug use. However, a recent review of cue exposure treatment for relapse prevention concluded that these treatments, although studied for years, were ineffective.

Patient Follow-up Strategies

Patient follow-up and continuing care have been found to be critical to preventing relapse and ensuring that patients remain abstinent. When relapse occurs, OTPs should facilitate reentry into MAT. Follow-up and continuing-care services ensure a continuum of support, and the consensus panel recommends that these efforts continue, with necessary funding to sustain them.

Referral to Social Services

Most patients in MAT need vocational, educational, housing, or other social services. OTPs should be proactive in educating social service providers about patient needs and facilitating these services. Patients in OTPs that provide assistance with social services have shown improved outcomes after treatment.

Involuntary Discharge From MAT

Unfortunately, involuntary discharge from MAT, sometimes called administrative discharge, occurs frequently. The consensus panel believes that these discharges are, in many cases, evidence of program shortcomings. A number of recent changes, including the Substance Abuse and Mental Health Services Administration (SAMHSA)-administered OTP accreditation system with its emphasis on patient care and rights and requirements for consistent policies and procedures, require OTPs to consider and document the reasons and methods for administrative discharges far more carefully than in the past. Other specific details vary from State to State.

The consensus panel strongly recommends that involuntary discharge be avoided if possible, especially when patients would like to remain in and might benefit from MAT. When discharge is unavoidable, it should be handled fairly and humanely, following procedural safeguards that comply with Federal regulations and accreditation guidelines.

Reasons for Administrative Discharge

SAMHSA accreditation guidelines mention "violence or threat of violence, dealing drugs, repeated loitering, [and] flagrant noncompliance resulting in an observable, negative impact on the program, staff, and other patients" as well as "nonpayment of fees" and "incarceration or other confinement" as possible causes for administrative discharge.

Patient and Employee Safety

OTPs are responsible for the safety and security of both patients and employees and for maintaining order in the facilities. Threats of violence should be taken seriously, and interventions should be rapid. Staff should document problem behavior.

Discharge for Continued Substance Abuse

The consensus panel recommends that patients receive every chance to continue treatment and that treatment last as long as it is effective. Program effectiveness may be determined by comparing a patient's substance use and overall adjustment at admission with his or her current status. The Addiction Severity Index, an assessment tool used in many substance abuse treatment programs, lends itself to such comparisons. Studies have shown significant improvement in patients even when complete abstinence was not achieved; therefore, caution should be used in judging patients' progress in MAT based solely on drug tests. Treatment for other substance use and addiction should be offered to patients coping with dual addictions. Patients should understand that the ultimate goals of treatment are abstinence from heroin and other illicit drugs and appropriate use of prescription medications.

Discharge for Nonpayment

An OTP should advise patients to inform the program of impending financial problems as soon as possible. OTPs should focus on helping patients who need financial assistance to pay for their treatment, through changes in their payment pattern or the identification of additional funds through Medicare, Medicaid, the U.S. Department of Veterans Affairs, health plan coverage, and other possible sources. If all of these avenues are exhausted and a patient must be discharged for inability to pay fees, then formal notice should precede discharge. Whenever possible, discharge should include referral to a program with a sliding fee scale or to an OTP receiving funding support through its State Authority. To ensure that patients are not cut off abruptly from medication, some OTPs seek payment for both the first and last months at admission. However, this may present serious obstacles for many patients, especially those in self-pay OTPs. OTPs should assist patients in seeking short-term loans or allow payments in smaller, more frequent installments if that will solve the problem. In 2003, the American Association for the Treatment of Opioid Dependence released new guidelines for addressing involuntary withdrawal from treatment for nonpayment.

Discharge for Incarceration

Unfortunately, MAT almost always is discontinued when patients are incarcerated. When patients face extended incarceration, OTPs should work with correctional facilities to ensure that appropriate and humane medication-tapering procedures

are followed and that medical safeguards are in place. Patients should be informed that, on release, they are eligible for readmission to their OTP without having to demonstrate signs and symptoms of withdrawal. They should be reassessed to determine the appropriate treatment phase. In cases of short-term detention, OTPs should determine whether the correctional system is continuing to medicate inmates with prescribed medications and, if it is not, OTPs should consider the practicality of offsite dosing.

Preventing and Finding Alternatives to Administrative Discharge

Communicating Program Rules Clearly

Including program rules in patient orientation and education is the first step to prevent administrative discharge. The consensus panel recommends that all OTPs develop, disseminate, and consistently enforce guidelines for patient behavior. Clear communication and awareness by both patients and staff members are important factors in preventing administrative discharge.

Staff members should identify behavioral problems as they emerge and respond to them promptly. Training in interpersonal techniques to handle aggressive or upset patients in nonprovocative ways should be part of training for all staff. The first responses to a behavioral problem should be to identify it, review the treatment plan, discuss the plan with the patient, and modify or intensify treatment to match the patient's treatment status. Remedial approaches to consider include the following:

- Reevaluate medication dosage, plasma levels, and metabolic responses, and adjust dosage for adequacy and patient comfort
- Assess co-occurring disorders, and provide psychotherapy and pharmacotherapy as needed
- Intensify counseling or add other types of counseling or ancillary services
- Treat medical or other associated problems
- Consider alternative medications
- Provide inpatient detoxification from substances of abuse, while maintaining patients on opioid pharmacotherapy
- Change counselors if indicated
- Reschedule dosing to times when more staff members are available
- Provide family intervention

Dosing should not be a behavioral tool--patients should not be disciplined by having their medication dosage decreased or withheld, nor should they be rewarded for good conduct by having their dosage increased. Programs are encouraged to develop nonpunitive ways to set limits and contain disruptive behavior. However, in some cases, involuntary discharge becomes necessary.

Finding Alternative Treatment Arrangements

Concerns that patients will discontinue medical treatment for or transmit disease (such as HIV/AIDS or hepatitis C) may lead staff members to ignore noncompliance problems to retain patients in a program. At times, such patients may have to be discharged, and the program should make referrals to a more appropriate level of care or type of treatment.

Procedures for Administrative Discharge

Ethical criteria for discharge include review and appeals processes, a suitable dosage protocol for withdrawal from medication, and a readmission procedure that includes a behavioral contract. Exact procedures depend on the reason for discharge. For behavioral problems, the approach should include escalating warnings and specified consequences including referral.

Review and Appeals Processes

Center for Substance Abuse Treatment (CSAT) accreditation guidelines recommend, and accreditation body standards require, due process and documentation during administrative discharge. OTP policies should include written guidelines, including confidentiality guidelines, under which cases of involuntary discharge can be appealed and examined by treatment and administrative staffs. Some States have developed regulations to guide this process. OTPs should have a formal appeal mechanism, and patients should be made aware of their rights. Staff members not directly involved with a disciplinary action should conduct a review of that action. OTPs should develop working relationships so that, when patients break rules and need to be discharged, they can be transferred to other programs.

Reviews and appeals should be handled promptly, with attention to procedural regularity and a patient's extenuating circumstances and point of view. Procedures should be fair and impartial because other patients' view of the program may be influenced by any perceived lack of fairness.

If a decision to discharge is made, supervised withdrawal of medication should begin after the review process is completed. Involuntary discharge should be done with the understanding that, if identified preconditions are met, the patient may return to the OTP within a specified time. Obstacles to reentry should be minimized. It is advisable to schedule a date on which the patient may return to talk about whether he or she may reenter the program.

Medically Supervised Tapering and Discontinuation

Whatever the reason for discharge, patients should be made as comfortable as possible during medically supervised withdrawal. Exact schedules require medical determination, but tapering should be as gradual as possible so that patients can find and enter other facilities.

Members of the consensus panel agree that blind withdrawal (withdrawing a patient from medical maintenance or adjusting dosages without his or her knowledge) is unethical unless requested by the patient to aid in the withdrawal process.

Patient Advocacy

Advocacy by and for patients in MAT and their supporters has emerged as a force on the treatment landscape. Several national and local advocacy groups with slightly different emphases have been organized, including the National Alliance of

Methadone Advocates, International Center for Advancement of Addiction Treatment, and Advocates for Recovery through Medicine. These groups believe that MAT is a lifesaving treatment, stigma must be reduced, and patients should be educated about their treatment and encouraged to participate in it. In general, these advocacy groups are made up of stable, long-term patients.

At the OTP level, advocacy groups focus on patient education and support, assistance with practical aspects of treatment, and public education about the benefits of MAT and constructive roles played by patients in many spheres. OTP-based patient advisory committees are becoming increasingly common. Participation in these organizations helps empower patients and enhance patient skills in social interaction. Other benefits include practice in group interaction and problem-solving. Patients gain a greater understanding of OTP operations and perspectives, educate others, identify problems and misinformation, and provide a channel of communication to OTP administration. Because accreditation agencies are concerned with input from patients, such involvement by patients usually is viewed favorably by these agencies.

CLINICAL ALGORITHM(S)

None provided

EVIDENCE SUPPORTING THE RECOMMENDATIONS

TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

Recommendations are based on a combination of clinical experience and research-based evidence.

BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

POTENTIAL BENEFITS

Increased patient retention in medication-assisted treatment for opioid addiction (MAT) resulting in increased positive outcomes

POTENTIAL HARMS

Not stated

QUALIFYING STATEMENTS

QUALIFYING STATEMENTS

The opinions expressed herein are the views of the consensus panel members and do not necessarily reflect the official position of Center for Substance Abuse Treatment (CSAT), Substance Abuse and Mental Health Services Administration (SAMHSA), or Department of Health and Human Services (DHHS). No official support of or endorsement by CSAT, SAMHSA, or DHHS for these opinions or for

particular instruments, software, or resources described in this document is intended or should be inferred. The guidelines in this document should not be considered substitutes for individualized client care and treatment decisions.

IMPLEMENTATION OF THE GUIDELINE

DESCRIPTION OF IMPLEMENTATION STRATEGY

Chapter 14, Administrative Considerations, in the original guideline document, covers the challenging administrative aspects of managing and staffing the complex and dynamic environment of an opioid treatment program (OTP). Successful treatment outcomes depend on the competence, values, and attitudes of staff members. To develop and retain a stable team of treatment personnel, program administrators must recruit and hire qualified, capable, culturally sensitive individuals; offer competitive salaries and benefit packages; and provide good supervision and ongoing training. Implementing community relations and community education efforts is important for opioid treatment programs. Outreach and educational efforts can dispel misconceptions about medication-assisted treatment for opioid addiction and people in recovery. Finally, the chapter provides a framework for gathering and analyzing program performance data. Program evaluation contributes to improved treatment services by enabling administrators to base changes in services on evidence of what works. Evaluation also serves as a way to educate and influence policymakers and public and private payers.

Refer to Chapter 14 in the original guideline document for full details (see "Companion Documents" field in this summary).

IMPLEMENTATION TOOLS

Quick Reference Guides/Physician Guides

For information about availability, see the "Availability of Companion Documents" and "Patient Resources" fields below.

INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

IOM CARE NEED

Getting Better
Living with Illness

IOM DOMAIN

Effectiveness
Patient-centeredness

IDENTIFYING INFORMATION AND AVAILABILITY

BIBLIOGRAPHIC SOURCE(S)

Approaches to providing comprehensive care and maximizing patient retention. In: Batki SL, Kauffman JF, Marion I, Parrino MW, Woody GE, Center for Substance Abuse Treatment (CSAT). Medication-assisted treatment for opioid addiction in opioid treatment programs. Rockville (MD): Substance Abuse and Mental Health Services Administration (SAMHSA); 2005. p. 121-42. (Treatment improvement protocol (TIP); no. 43).

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Not applicable: The guideline was not adapted from another source.

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GUIDELINE COMMITTEE

Treatment Improvement Protocol (TIP) Series 43 Consensus Panel

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FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST

Not stated

GUIDELINE STATUS

This is the current release of the guideline.

GUIDELINE AVAILABILITY

Electronic copies: Available from the National Library of Medicine Health Services/Technology Assessment (HSTAT) Web site. Also available in Portable Document Format (PDF) from SAMHSA's National Clearinghouse for Alcohol and Drug Information (NCADI) Web site.

Print copies: Available from the National Clearinghouse for Alcohol and Drug Information (NCADI), P.O. Box 2345, Rockville, MD 20852. Publications may be ordered from NCADI's Web site or by calling (800) 729-6686 (United States only).

AVAILABILITY OF COMPANION DOCUMENTS

The following are available:

- Executive summary. Medication-assisted treatment for opioid addiction in opioid treatment programs. p. xvii-xx. (Treatment improvement protocol (TIP); no. 43).
- Introduction. Medication-assisted treatment for opioid addiction in opioid treatment programs. p. 1-10. (Treatment improvement protocol (TIP); no. 43).
- History of medication-assisted treatment for opioid addiction. Medication-assisted treatment for opioid addiction in opioid treatment programs. p. 11-23. (Treatment improvement protocol (TIP); no. 43).
- Pharmacology of medications used to treat opioid addiction. Medication-assisted treatment for opioid addiction in opioid treatment programs. p. 25-42. (Treatment improvement protocol (TIP); no. 43).
- Administrative considerations. Medication-assisted treatment for opioid addiction in opioid treatment programs. p. 225-240. (Treatment improvement protocol (TIP); no. 43).
- Appendix D: Ethical considerations in MAT. Medication-assisted treatment for opioid addiction in opioid treatment programs. p. 297-304. (Treatment improvement protocol (TIP); no. 43).

Electronic copies: Available from the National Library of Medicine Health Services/Technology Assessment (HSTAT) Web site. Also available in Portable Document Format (PDF) from SAMHSA's National Clearinghouse for Alcohol and Drug Information (NCADI) Web site.

The following are also available:

- Knowledge Application Program. KAP keys for clinicians. Based on TIP 43: Medication-assisted treatment for opioid addiction in opioid treatment programs. Rockville (MD): Substance Abuse and Mental Health Services Administration (SAMHSA); 2005. 20 p. Electronic copies: Available in Portable Document Format (PDF) from the SAMHSA Web site.
- Quick guide for clinicians. Based on TIP 43: Medication-assisted treatment for opioid addiction in opioid treatment programs. Rockville (MD): Substance Abuse and Mental Health Services Administration (SAMHSA); 2005. 39 p. Electronic copies: Available in Portable Document Format (PDF) from the SAMHSA Web site.

PATIENT RESOURCES

None available

NGC STATUS

This NGC summary was completed by ECRI on December 23, 2005. The information was verified by the guideline developer on January 23, 2006.

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